Notice:

Some decisions we would rather put off indefinitely. Designating what kind of medical care we want if we become unable to speak for ourselves is one of those decisions.

Anything that forces us to think about our own mortality makes most of us uncomfortable. Nevertheless, it is smart and thoughtful to make such a decision before they become necessary. By taking the initiative, our loved ones do not have to guess what our desires would have been. Pre-planning can eliminate much of the confusion and trauma.

Attached is a Durable Power of Attorney for Health Care form which might make this pre-planning a little easier.

We, at the Jacobetti Home for Veterans, encourage our members to complete this form prior to admission. If you have any questions, please feel free to call upon the staff at the Jacobetti Veterans Home for further assistance.

Attachment

D.J. JACOBETTI HOME FOR VETERANS

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, am of sound mind, and I voluntarily make
(PRINT OR TYPE YOUR FULL NAME)
this designation.

I designate _____, my _____,
(INSERT NAME OF PATIENT ADVOCATE) (SPOUSE, CHILD, FRIEND)

living at_____
(ADDRESS OF PATIENT ADVOCATE)
as my patient advocate to make care, custody and medical treatment decisions for me in the event I become unable to participate in medical treatment decisions. If my first choice cannot serve, I designate _____
(NAME OF SUCCESSOR)
to serve as my patient advocate.

The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

In making decisions for me, my patient advocate shall follow my wishes of which he or she is aware, whether expressed orally, in a living will, or in this designation.

My patient advocate has authority to consent or to refuse treatment on my behalf, to arrange medical services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds. My patient advocate shall have access to any of my medical records to which I have a right.

OPTIONAL

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die and I acknowledge such decisions could or would allow my death.

_____
Sign here if you wish to give your patient advocate this authority

_____	_____	_____
Social Security Number	Date of Birth	Mother's Maiden name

My specific wishes concerning health care are the following: (if none, write "none")_____

_____

_____

_____

I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

It is my intent that my family, the medical facility, and any doctors, nurses, and other medical personnel involved in my care shall have no civil or criminal liability for honoring my wishes expressed in this designation or for implementing the decisions of my patient advocate.

Photo static copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Dated:_____ Signed:_____

Address:_____

_____

NOTICE REGARDING WITNESSES

You must have two adult witnesses who will not receive your assets when you die (whether you die with or without a will), and who are not your spouse, child, grandchild, brother or sister, an employee of a company through which you have life or health insurance, or an employee at the health facility where you are a patient.

(Exception: where other witnesses are not reasonably available, employees of the Chaplain Service, Psychology Service, Social Work Service, or nonclinical employees such as Voluntary Service or Environmental Management Service may serve as witnesses.)

STATEMENT OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

Signed by witness:_____

_____
(Print or type full name)

Address:_____

_____

Signed by witness:_____

_____
(Print or type full name)

Address:_____

_____

Acceptance by Patient Advocate

A. This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

B. A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

C. This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

D. A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

E. A patient advocate shall not receive compensation for the performance of his or her authority, rights and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights and responsibilities.

F. A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.

G. A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

H. A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

I. A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Complied Laws.

I understand the above conditions, and I accept the designation as patient advocate for:

_____

Dated:_____ Signed:_____

(Patient Advocate)

Dated:_____ Signed:_____

(Successor Patient Advocate)